APPEAL REQUEST FORM - ELIGIBILITY

(An appeal may only be made after receiving a Notice of Action)

Note: If you cannot read or understand this form, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

APPLICANT/MEMBER INFORMATION

Name (Last) (First) afafa	Birth Date: Mo. Day Yr.	Medical Record # DMH IS #:
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Cell)	(Alternate)
Name of person completing form, if different from applicant name		(Daytime Telephone)

Please attach a copy of your Notice of Action	Notice of Action Date:

Please tell us why you do not agree with the decision about your enrollment or continued enrollment in Healthy Way LA (HWLA). You may attach any papers that support your appeal. **For additional space use the attached form (page 2) or add another piece of paper.**

For decisions ending Member's enrollment only: Are you asking for services to keep going during the appeal? Yes ☐ No ☐
If yes, then you may have to pay for the cost of services if you lose the appeal.

If you think your situation is urgent, and waiting 45 days will put at serious risk your life, health or your ability to get back the most function possible, tell us what may happen without a quick decision:

Does your doctor agree that this situation is urgent? Yes ☐ No ☐

I understand that Healthy Way LA will contact me within forty-five (45) days to give me a decision on my appeal.

_____ _____
Signature of applicant/member or applicant's/member's representative Date

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Please tell us why you do not agree with the decision about your HWLA application. **For additional space add another piece of paper.**

Please return this form to the Department of Mental Health Patients' Rights by doing one of the following:

- Fax it to the Department of Mental Health Patients' Rights at (213) 365-2481
- Return form in person to clinic or application site
- Return form in person to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue. Los Angeles, CA 90020
- Mail it to Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020

INTERNAL USE ONLY
(Complete only if a Potential Expedited Appeal) Definition: An expedited appeal is one that involves an issue that could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Member was told that the expedited appeal would be decided within three working days of its receipt? Yes ☐ No ☐ Member was told to provide supporting documentation by the next working day? Yes ☐ No ☐
Date Appeal Acknowledgement Given:
1. Clinic: 2. Appeal Code: 3. Appeal received : In Person ☐ By Phone ☐ By Mail ☐ By Fax ☐
Appeal Received By: Time: Date: